Commonwealth of Massachusetts
Department of Public Safety

ELEVATOR INCIDENT REPORT

*This form must be faxed to the Department at **(617) 248-0813** or scanned and e-mailed to DPSaccidentreport@state.ma.us within 48 hours of serious injury.*

Please provide complete information below.

Elevator Owner:		**Elevator Tag #**	
Elevator Location Address:		**Location of Accident:**	
		Permit Expiration Date:	
Elevator Owner Contact Name:		**Accident Date:**	
Elevator Owner Contact Phone #:		**Accident Time:**	
Date of First Report to DPS:		**Time of First Report to DPS:**	
Name of Person Filing Report (if different than Owner Contact):		**Phone # (if different than Owner Contact Phone):**	
How was the owner notified of the accident?:			

Was the elevator taken out of service at the time of the incident? **❑ Yes ❑ No**	**Has the elevator been put back into service?** **❑ Yes** **❑ No**	**If yes, on what date was the elevator put back in service and who authorized its reactivation?**

WITNESS INFORMATION

WITNESSES	NAME OF WITNESSES OR PERSONS PRESENT	ADDRESS	PHONE

ACCIDENT / VICTIM INFORMATION

INJURED 1	Name of injured:	Sex: ❑ Female ❑ Male
	DOB:	Street Address: City/State/Zip Code
	Was there an on-scene medical provider? ❑ Yes ❑ No	If yes, on-scene medical provider's name and telephone #:
	Hospitalized? ❑ Yes ❑ No Nature of injury:	

INJURED 2	Name of injured:	Sex: ❑ Female ❑ Male
	DOB:	Street Address: City/State/Zip Code
	Was there an on-scene medical provider? ❑ Yes ❑ No	If yes, on-scene medical provider's name and telephone #:
	Hospitalized? ❑ Yes ❑ No Nature of injury:	

INJURED 3	Name of injured:	Sex: ❑ Female ❑ Male
	DOB:	Street Address: City/State/Zip Code
	Was there an on-scene medical provider? ❑ Yes ❑ No	If yes, on-scene medical provider's name and telephone #:
	Hospitalized? ❑ Yes ❑ No Nature of injury:	

INCIDENT / ACCIDENT SUMMARY

Signature of individual filing report:_____ Date:_____

Name of individual filing report (print legibly):_____

INCIDENT / ACCIDENT SUMMARY (SUPPLEMENTAL SHEET)

Witness or Victim Report:

Signature:_____ Date:_____

Print Name:_____